CLAY COUNTY HOSPITAL

FLORA, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED FEBRUARY 28, 2010

PROVIDER NO. 14-1351 CLAY COUNTY HOSPITAL
PERIOD FROM 03/01/2009 TO 02/28/2010

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2010.02
06/21/2010 09:20

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I & II

INTERMEDIARY USE ONLY: [ ] AUDITED [ ] DESK REVIEWED
DATE RECEIVED _____ INTERMEDIARY NO. _____
[ ] INITIAL [ ] FINAL [ ] RE-OPENING [ ] MCR CODE

PART I - CERTIFICATION

CHECK APPLICABLE BOX
XX ELECTRONICALLY FILED COST REPORT
__ MANUALLY SUBMITTED COST REPORT
DATE: 06/21/2010
TIME: 09:20

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY CLAY COUNTY HOSPITAL (14-1351) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 03/01/2009 AND ENDING 02/28/2010, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 06/21/2010 09:20
KfuvT..bry5DOEKRN4tDoVYEbp8h30
hcgdX0cnhxAilI:wOeLi:z3oNlAbRd
MXOx0VT5sE0KZZz:

PI Encryption: 06/21/2010 09:20
OUxtoaF4FwcGp41LVRAqp8qGJzmKn0
qPm8q0TU3LO5E9psTLdkQhrpwDxEdh
uj:P5nbik60iyZzd

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			PART A	PART B		
		1	2	3	4	
1	HOSPITAL		697328	211351	-4278	1
2	SUBPROVIDER I					2
3	SWING BED - SNF		44500			3
4	SWING BED - NF					4
5	SKILLED NURSING FACILITY					5
6	NURSING FACILITY					6
7	HOME HEALTH AGENCY					7
8	OUTPATIENT REHABILITATION PROVIDER					8
9	RURAL HEALTH CLINIC I			-29136		9
9.01	RURAL HEALTH CLINIC II					9.01
100	TOTAL		741828	182215	-4278	100

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 911 STACY BURK DRIVE — P.O.BOX: — 1

1.01 CITY: FLORA — STATE: IL — ZIP CODE: 62839-0280 — COUNTY: CLAY — 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	PROVIDER NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	
2	HOSPITAL	CLAY COUNTY HOSPITAL	14-1351	12/21/2005	N	O	O	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	CLAY COUNTY SWING BED	14-Z351	12/21/2005	N	O	N	4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF							6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA							9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC	CLAY COUNTY MEDICAL CLINIC	14-3458	11/29/2005	N	O	N	14
14.01	HOSP-BASED RHC II	LOUISVILLE MEDICAL CLINIC	14-3487	12/18/2006	N	O	N	14.01
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16

17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 03/01/2009 TO: 02/28/2010	17
		1 2	
18	TYPE OF CONTROL	9	18

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	1	19
20	SUBPROVIDER I		20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.		21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 'Y' OR 'N' FOR NO.		21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.		21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2	Y 21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2	21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2	21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105 OR MIPPA 147? (SEE INSTRUCTIONS). ENTER 'Y' FOR YES AND 'N' FOR NO.	NO	21.06
21.07	DOES THIS HOSPITAL QUALIFY AS AN SCH WITH UNDER 100 BEDS OR FEWER BEDS UNDER MIPPA 147? ENTER 'Y' FOR YES AND 'N' FOR NO (SEE INSTRUCTIONS).	NO	21.07
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS? ENTER IN COLUMN 1, 1 IF IT IS BASED ON DATE OF ADMISSION, 2 IF IT IS BASED ON CENSUS DAYS, OR 3 IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE LAST COST REPORTING PERIOD? ENTER IN COLUMN 2, 'Y' FOR YES AND 'N' FOR NO.		21.08
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	NO	22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW	NO	23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COl. 3.		23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.		23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.		24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.		24.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO		25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO		25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO		25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO		25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO		25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			25.06
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:			26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.			26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:			26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	01/25/1985	27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.			28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st			28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) If YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY. A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)			28.02
28.03	STAFFING	0.00	NO	28.03
28.04	RECRUITMENT	0.00	NO	28.04
28.05	RETENTION OF EMPLOYEES	0.00	NO	28.05
28.06	TRAINING	0.00	NO	28.06
28.07	OTHER (SPECIFY)		NO	28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO		29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES		30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO		30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	NO		30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)	NO		30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.	NO		30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO		31

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA — WORKSHEET S-2 (CONTINUED)

MISCELLANEOUS COST REPORTING INFORMATION

32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO	32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.	NO	33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO	34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO	35

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL

		V	XVIII	XIX	
		1	2	3	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?				37.01

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES	38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO	38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO	38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO	38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO	38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COL. 2 THE HOME OFFICE CHAIN NUMBER. (SEE INST.) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE ON LINES 40.01-40.03.	NO		40
40.01	NAME: FI/CONTRACTOR'S NAME:	FI/CONTRACTOR'S NUMBER:		40.01
40.02	STREET:	P.O.BOX:		40.02
40.03	CITY:	STATE: ZIP CODE:		40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YES		41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO		42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO		42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO		42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO		43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO		44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO		45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?			45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?			45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?			45.03
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.			46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

		PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
		1	2	3	4	5	
47	HOSPITAL	N	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N				49
50	HOME HEALTH AGENCY	N	N				50

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?	NO	52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.	NO	52.01
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		53
53.01	MDH PERIOD: BEGINNING: ENDING:		53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		54
	PREMIUMS: 223979 PAID LOSSES: AND/OR SELF INSURANCE:		
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	YES	54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.	NO	55

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

		DATE 0	Y/N 1	LIMIT 2	Y/N 3	FEES 4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO		56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		NO				57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		NO				58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)						58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				59
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)						60.01

MULTICAMPUS

61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO.		NO				61
	IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.						
		COUNTY: 1	STATE: 2	ZIP CODE 3	CBSA 4	FTE/ CAMPUS 5	

SETTLEMENT DATA

63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)		NO				63

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH PATIENT HOURS	I/P DAYS / O/P VISITS / TRIPS				
					TITLE V	TITLE XVIII	LTCH NONCOVERED DAYS	TITLE XIX	OBS. BEDS ADMITTED
		1	2	2.01	3	4	4.01	5	5.01	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	22	8030	112128.0		2808		317		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					401				3
4	HOSPITAL ADULTS & PEDS - SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	22	8030	112128.0		3209		317		5
6	INTENSIVE CARE UNIT									6
7	CORONARY CARE UNIT									7
8	BURN INTENSIVE CARE UNIT									8
9	SURGICAL INTENSIVE CARE UNIT									9
10	OTHER SPECIAL CARE (SPECIFY)									10
11	NURSERY									11
12	TOTAL HOSPITAL	22	8030	112128.0		3209		317		12
13	RPCH VISITS									13
14	SUBPROVIDER I									14
15	SKILLED NURSING FACILITY									15
16	NURSING FACILITY									16
17	OTHER LONG TERM CARE									17
18	HOME HEALTH AGENCY									18
20	ASC (DISTINCT PART)									20
21	HOSPICE (DISTINCT PART)									21
23	O/P REHAB PROVIDER									23
24	RHC I					5468				24
24.01	RHC II									24.01
25	TOTAL	22								25
26	OBSERVATION BED DAYS							41	1	26
27	AMBULANCE TRIPS					746				27
28	EMPLOYEE DISCOUNT DAYS									28
29	LABOR & DELIVERY DAYS									29

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	I/P DAYS OBS. BEDS NOT ADMITTED 5.02	I/P DAYS TOTAL ALL PATIENTS 6	O/P VISITS OBS. BEDS ADMITTED 6.01	TRIPS OBS. BEDS NOT ADMITTED 6.02	INTERNS & RES FTES TOTAL 7	INTERNS & RES FTES LESS I&R REPL PHYS 8	INTERNS & RES FTES LESS I&R REPL NON-ANES 8	INTERNS & RES FTES NET 9	FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	FULL TIME EQUIV NONPAID WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		3708									1
2	HMO XIX											2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF		401									3
4	HOSPITAL ADULTS & PEDS - SWING BED NF											4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		4109									5
6	INTENSIVE CARE UNIT											6
7	CORONARY CARE UNIT											7
8	BURN INTENSIVE CARE UNIT											8
9	SURGICAL INTENSIVE CARE UNIT											9
10	OTHER SPECIAL CARE (SPECIFY)											10
11	NURSERY											11
12	TOTAL HOSPITAL		4109							133.40		12
13	RPCH VISITS											13
14	SUBPROVIDER I											14
15	SKILLED NURSING FACILITY											15
16	NURSING FACILITY											16
17	OTHER LONG TERM CARE											17
18	HOME HEALTH AGENCY											18
20	ASC (DISTINCT PART)											20
21	HOSPICE (DISTINCT PART)											21
23	O/P REHAB PROVIDER											23
24	RHC I		21857							23.90		24
24.01	RHC II											24.01
25	TOTAL									164.70		25
26	OBSERVATION BED DAYS	40	215	7	208							26
27	AMBULANCE TRIPS											27
28	EMPLOYEE DISCOUNT DAYS											28
29	LABOR & DELIVERY DAYS											29

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	DISCHARGES TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		757	107	1054	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		757	107	1054	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
24.01	RHC II					24.01
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

RHC I
COMPONENT NO: 14-3458

WORKSHEET S-8

PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER
PROVIDER STATISTICAL DATA

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 929 STACY BURK DRIVE 1

1.01 CITY: FLORA STATE: IL ZIP CODE: 62839 COUNTY: CLAY 1.01

2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 2	
3 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)		/ /	3
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /	4
5 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)		/ /	5
6 APPALACHIAN REGIONAL COMMISSION		/ /	6
7 LOOK-ALIKES		/ /	7
8 OTHER		/ /	8

PHYSICIAN INFORMATION:

9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT — PHYSICIAN NAME — BILLING NO. — 9

10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD — PHYSICIAN NAME — HOURS — 10

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO 11
IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2
(ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION 0	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14	
12	CLINIC			800	1700	800	1700	800	1700	800	1700	800	1700			12

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS OF OPERATION)
LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? NO 13

14 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? YES 2 14
IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT.
LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.

15 PROVIDER NAME: CLAY COUNTY HOSPITAL CLIN PROVIDER NUMBER: 14-3458 15

15.01 LOUISVILLE MEDICAL CLINIC 14-3487 15.01

V XVIII XIX

16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS. NO 16

17 HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, SEE INSTRUCTIONS. NO 17

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES — WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI-FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXP FOR ALLOCATION 7	
		GENERAL SERVICE COST CENTERS								
1	0100	OLD CAP REL COSTS-BLDG & FIXT								1
2	0200	OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300	NEW CAP REL COSTS-BLDG & FIXT		1034288	1034288	-186922	847366	-175675	671691	3
3.01	0301	NEW CAP RHC REL COSTS-BLDG & FI		21089	21089	180930	202019		202019	3.01
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		691727	691727	5992	697719		697719	4
5	0500	EMPLOYEE BENEFITS	76280	2171201	2247481		2247481	-13494	2233987	5
6	0600	ADMINISTRATIVE & GENERAL	650002	1163395	1813397		1813397	-129037	1684360	6
7	0700	MAINTENANCE & REPAIRS								7
8	0800	OPERATION OF PLANT	140757	355020	495777		495777		495777	8
8.01	0801	RHC UTILITY EXPENSE		30226	30226		30226		30226	8.01
9	0900	LAUNDRY & LINEN SERVICE		76498	76498		76498		76498	9
10	1000	HOUSEKEEPING	183568	41711	225279		225279		225279	10
11	1100	DIETARY	189217	148058	337275		337275	-96556	240719	11
12	1200	CAFETERIA								12
13	1300	MAINTENANCE OF PERSONNEL								13
14	1400	NURSING ADMINISTRATION	269455	23444	292899		292899		292899	14
15	1500	CENTRAL SERVICES & SUPPLY	22771	-845	21926		21926		21926	15
16	1600	PHARMACY	169302	11885	181187		181187		181187	16
17	1700	MEDICAL RECORDS & LIBRARY	244212	46718	290930		290930	-5702	285228	17
18	1800	SOCIAL SERVICE								18
20	2000	NONPHYSICIAN ANESTHETISTS								20
21	2100	NURSING SCHOOL								21
22	2200	I&R SERVICES-SALARY & FRINGES A								22
23	2300	I&R SERVICES-OTHER PRGM COSTS A								23
24	2400	PARAMED ED PRGM-(SPECIFY)								24
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	984306	49191	1033497		1033497		1033497	25
		ANCILLARY SERVICE COST CENTERS								
37	3700	OPERATING ROOM	373411	169370	542781	9397	552178		552178	37
40	4000	ANESTHESIOLOGY		246617	246617	-9397	237220	-237220		40
41	4100	RADIOLOGY-DIAGNOSTIC	305497	551569	857066		857066		857066	41
44	4400	LABORATORY	378228	670523	1048751		1048751		1048751	44
46.30	4650	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900	RESPIRATORY THERAPY	227890	21513	249403	-45577	203826	-3763	200063	49
50	5000	PHYSICAL THERAPY	400497	17018	417515		417515		417515	50
53	5300	ELECTROCARDIOLOGY	15123	6960	22083	34183	56266	-15123	41143	53
54	5400	ELECTROENCEPHALOGRAPHY		56765	56765	11394	68159	-56600	11559	54
55	5500	MEDICAL SUPPLIES CHARGED TO PAT		380701	380701		380701	-384	380317	55
56	5600	DRUGS CHARGED TO PATIENTS		388882	388882		388882		388882	56
59	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVI		447817	447817		447817		447817	59
59.97	3997	CARDIAC REHABILITATION								59.97
59.98	3998	HYPERBARIC OXYGEN THERAPY								59.98
59.99	3999	LITHOTRIPSY								59.99
		OUTPATIENT SERVICE COST CENTERS								
61	6100	EMERGENCY	445372	1316398	1761770		1761770	-716263	1045507	61
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310	RHC	1711170	240129	1951299		1951299	-119600	1831699	63.50
63.60	6320	FQHC								63.60
		OTHER REIMBURSABLE COST CENTERS								
65	6500	AMBULANCE SERVICES	366507	61632	428139		428139		428139	65
69.10	6910	CMHC								69.10
69.20	6920	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930	OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940	OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100	HOME HEALTH AGENCY								71
		SPECIAL PURPOSE COST CENTERS								
85.01	8510	PANCREAS ACQUISITION								85.01
85.02	8520	INTESTINAL ACQUISITION								85.02
85.03	8530	ISLET CELL ACQUISITION								85.03
95		SUBTOTALS	7153565	10439500	17593065		17593065	-1569417	16023648	95
		NONREIMBURSABLE COST CENTERS								
96	9600	GIFT, FLOWER, COFFEE SHOP & CAN								96
98	9800	PHYSICIANS' PRIVATE OFFICES	28716	8083	36799		36799		36799	98
101		TOTAL	7182281	10447583	17629864		17629864	-1569417	16060447	101

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5	
1	DEPRICIATION	A	NEW CAP RHC REL COSTS-BLDG &	3.01		174768	1
2	RESPIRATORY THERAPY	B	ELECTROCARDIOLOGY	53	34183		2
3		B	ELECTROENCEPHALOGRAPHY	54	11394		3
4	INSURANCE EXPENSE	C	NEW CAP RHC REL COSTS-BLDG &	3.01		6162	4
5		C	NEW CAP REL COSTS-MVBLE EQUIP	4		5992	5
6	OPERATING ROOM	D	OPERATING ROOM	37		9397	6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				45577	196319	36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	DEPRICIATION	A	NEW CAP REL COSTS-BLDG & FIXT	3		174768	9	1
2	RESPIRATORY THERAPY	B	RESPIRATORY THERAPY	49	45577			2
3		B						3
4	INSURANCE EXPENSE	C	NEW CAP REL COSTS-BLDG & FIXT	3		12154	12	4
5		C					12	5
6	OPERATING ROOM	D	ANESTHESIOLOGY	40		9397		6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36	TOTAL RECLASSIFICATIONS				45577	196319		36

ANALYSIS OF CHANGES DURING COST REPORTING
PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL
AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED
TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND								1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES								3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT								6
7	SUBTOTAL								7
8	RECONCILING ITEMS								8
9	TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND	132111					132111		1
2	LAND IMPROVEMENTS	345852					345852		2
3	BUILDINGS AND FIXTURES	11912380	28431		28431		11940811		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	6042459	145743		145743	472277	5715925		5
6	MOVABLE EQUIPMENT								6
7	SUBTOTAL	18432802	174174		174174	472277	18134699		7
8	RECONCILING ITEMS								8
9	TOTAL	18432802	174174		174174	472277	18134699		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

	DESCRIPTION	COMPUTATION OF RATIOS: GROSS ASSETS	COMPUTATION OF RATIOS: CAPITALIZED LEASES	COMPUTATION OF RATIOS: GROSS ASSETS FOR RATIO	COMPUTATION OF RATIOS: RATIO	ALLOCATION OF OTHER CAPITAL: INSURANCE	ALLOCATION OF OTHER CAPITAL: TAXES	ALLOCATION OF OTHER CAPITAL: OTHER CAPITAL-RELATED COSTS	ALLOCATION OF OTHER CAPITAL: TOTAL	
		1	2	3	4	5	6	7	8	
1	OLD CAP REL COSTS-BLDG & FIXT				.000000					1
2	OLD CAP REL COSTS-MVBLE EQUIP				.000000					2
3	NEW CAP REL COSTS-BLDG & FIXT	10525851		10525851	.584685					3
3.01	NEW CAP RHC REL COSTS-BLDG & FI	1760812		1760812	.097809					3.01
4	NEW CAP REL COSTS-MVBLE EQUIP	5715925		5715925	.317506					4
5	TOTAL	18002588		18002588	1.000000					5

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL: DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	493310		149383	28998			671691	3
3.01	NEW CAP RHC REL COSTS-BLDG & FIX	174768	18144		6162	2945		202019	3.01
4	NEW CAP REL COSTS-MVBLE EQUIP	508481	183246		5992			697719	4
5	TOTAL	1176559	201390	149383	41152	2945		1571429	5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL: DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	668078		325058	41152			1034288	3
3.01	NEW CAP RHC REL COSTS-BLDG & FIX		18144			2945		21089	3.01
4	NEW CAP REL COSTS-MVBLE EQUIP	508481	183246					691727	4
5	TOTAL	1176559	201390	325058	41152	2945		1747104	5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-NEW BLDGS & FIXTURES	B	-175675	NEW CAP REL COSTS-BLDG & FIXT	3	11	3
4	INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		4
5	INVESTMENT INCOME-OTHER						5
6	TRADE, QUANTITY, AND TIME DISCOUNTS						6
7	REFUNDS AND REBATES OF EXPENSES						7
8	RENTAL OF PROVIDER SPACE BY SUPPLIERS	B	-1400	ADMINISTRATIVE & GENERAL	6		8
9	TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-3215	ADMINISTRATIVE & GENERAL	6		9
10	TELEVISION AND RADIO SERVICE						10
11	PARKING LOT						11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-830001				12
13	SALE OF SCRAP, WASTE, ETC.	B	-695	ADMINISTRATIVE & GENERAL	6		13
14	RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1					14
15	LAUNDRY AND LINEN SERVICE						15
16	CAFETERIA - EMPLOYEES AND GUESTS	B	-96556	DIETARY	11		16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-384	MEDICAL SUPPLIES CHARGED TO PAT	55		18
19	SALE OF DRUGS TO OTHER THAN PATIENTS						19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-5702	MEDICAL RECORDS & LIBRARY	17		20
21	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						21
22	VENDING MACHINES	B	-3	ADMINISTRATIVE & GENERAL	6		22
23	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES						23
24	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						24
25	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49		25
26	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50		26
27	ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST A-8-3		HOME HEALTH AGENCY	71		27
28	UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89		28
29	DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		29
30	DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		30
31	DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		31
32	DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		32
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20		33
34	PHYSICIANS' ASSISTANT						34
35	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4					35
36	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4					36
37	EKG PHYSICIAN EMPLOYEE BENEFITS	A	-7556	EMPLOYEE BENEFITS	5		37
38	MISCELLANEOUS REVENUE	B	-29323	ADMINISTRATIVE & GENERAL	6		38
39	PUBLIC RELATIONS	A	-87066	ADMINISTRATIVE & GENERAL	6		39
40	LOBBYING EXPENSE	A	-7335	ADMINISTRATIVE & GENERAL	6		40
41	CRNA EXPENSE	A	-237220	ANESTHESIOLOGY	40		41
42	EMPLOYEE BENEFITS LAB TESTS	A	-5938	EMPLOYEE BENEFITS	5		42
43							43
44	PHYSICIAN CLINIC EXPENSE	A	-81348	RHC	63.50		44
45							45
46							46
47							47
48							48
49							49
50	TOTAL		-1569417				50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS — WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ-USTMENTS	WKST A-7 REF	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5		TOTALS						5

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

			-------- RELATED ORGANIZATION(S) AND/OR HOME OFFICE ----------				
	SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
- B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
- C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
- D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
- E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
- F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
- G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERATION INCL FRINGES 3	PROFESSIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	PERCENT OF UNADJUSTED RCE LIMIT 9
1	44	LABORATORY		30500		30500				
2	63.50	RHC	AGGREGATE	38252	38252					
3	53	ELECTROCARDIOLOGY	AGGREGATE	15123	15123					
4	61	EMERGENCY	AGGREGATE	1243513	716263	527250				
5	54	ELECTROENCEPHALOGRAPHY	AGGREGATE	56600	56600					
6	49	RESPIRATORY THERAPY	AGGREGATE	3763	3763					
101		TOTAL		1387751	830001	557750				

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18
1	44	LABORATORY								
2	63.50	RHC	AGGREGATE							38252
3	53	ELECTROCARDIOLOGY	AGGREGATE							15123
4	61	EMERGENCY	AGGREGATE							716263
5	54	ELECTROENCEPHALOGRAPHY	AGGREGATE							56600
6	49	RESPIRATORY THERAPY	AGGREGATE							3763
101		TOTAL								830001

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW RHC BUILDING FIXTURES 3.01	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT	671691	671691							3
3.01	NEW CAP RHC REL COSTS-BLDG & FI	202019		202019						3.01
4	NEW CAP REL COSTS-MVBLE EQUIP	697719			697719					4
5	EMPLOYEE BENEFITS	2233987			526	2234513				5
6	ADMINISTRATIVE & GENERAL	1684360	294653		51676	207507	2238196	2238196		6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT	495777	5074		12801	44935	558587	90450	649037	8
8.01	RHC UTILITY EXPENSE	30226					30226	4894		8.01
9	LAUNDRY & LINEN SERVICE	76498			222		76720	12423		9
10	HOUSEKEEPING	225279	2784		1164	58602	287829	46607	4857	10
11	DIETARY	240719	11830		11678	60406	324633	52567	20643	11
12	CAFETERIA		3796				3796	615	6623	12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION	292899	4087		929	86021	383936	62170	7131	14
15	CENTRAL SERVICES & SUPPLY	21926	5517		2301	7269	37013	5993	9626	15
16	PHARMACY	181187	3075		2213	54048	240523	38947	5365	16
17	MEDICAL RECORDS & LIBRARY	285228	41640		17690	77962	422520	68417	72657	17
18	SOCIAL SERVICE									18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	1033497	81673		36394	314230	1465794	237352	142511	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	552178	51458		62896	119208	785740	127233	89790	37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC	857066	38009		290372	97527	1282974	207748	66321	41
44	LABORATORY	1048751	12083		62113	120746	1243693	201387	21084	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY	200063	4251		8789	57000	270103	43737	7418	49
50	PHYSICAL THERAPY	417515		49688	18416	127855	613474	99338		50
53	ELECTROCARDIOLOGY	41143	4251		4144	10913	60451	9789	7418	53
54	ELECTROENCEPHALOGRAPHY	11559	4239		2676	3637	22111	3580	7396	54
55	MEDICAL SUPPLIES CHARGED TO PAT	380317					380317	61584		55
56	DRUGS CHARGED TO PATIENTS	388882					388882	62970		56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	447817	32669				480486	77804	57004	59
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	1045507	34428		18746	142181	1240862	200929	60073	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	1831699		140809	50756	518295	2541559	411549		63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES	428139	16069		40796	117004	602008	97481	28039	65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	16023648	651586	190497	697298	2225346	15982433	2225564	613956	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN		3404				3404	551	5939	96
98	PHYSICIANS' PRIVATE OFFICES	36799	16701	11522	421	9167	74610	12081	29142	98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	16060447	671691	202019	697719	2234513	16060447	2238196	649037	103

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	RHC UTILITY EXPENSE 8.01	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINIS-TRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
3.01	NEW CAP RHC REL COSTS-BLDG & FI									3.01
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
8.01	RHC UTILITY EXPENSE	35120								8.01
9	LAUNDRY & LINEN SERVICE		89143							9
10	HOUSEKEEPING			339293						10
11	DIETARY		1348	13884	413075					11
12	CAFETERIA			15346	291485	317865				12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION			639		10508	464384			14
15	CENTRAL SERVICES & SUPPLY		1368	2375		2627	5893	64895		15
16	PHARMACY			2877		5254	12539	28	305533	16
17	MEDICAL RECORDS & LIBRARY			3266		21016				17
18	SOCIAL SERVICE									18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		42159	107921	121590	70927	160807	1200		25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		10627	47338		18389	43515	23169		37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC		8919	20598		18389	40249	2709		41
44	LABORATORY			11829		26270	57280	25798		44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY			12308		13135	31678	660		49
50	PHYSICAL THERAPY	8638	4978	11327		18389		850		50
53	ELECTROCARDIOLOGY		1307	1987				14		53
54	ELECTROENCEPHALOGRAPHY			183						54
55	MEDICAL SUPPLIES CHARGED TO PAT							7310		55
56	DRUGS CHARGED TO PATIENTS								305533	56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI			3745						59
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		13832	39049		21016	53148	1525		61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	24479	1853	29275		63048		1397		63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES		2752	594		26270	59275	235		65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	33117	89143	324541	413075	315238	464384	64895	305533	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN			2101						96
98	PHYSICIANS' PRIVATE OFFICES	2003		12651		2627				98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	35120	89143	339293	413075	317865	464384	64895	305533	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 17	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 27	
	GENERAL SERVICE COST CENTERS					
1	OLD CAP REL COSTS-BLDG & FIXT					1
2	OLD CAP REL COSTS-MVBLE EQUIP					2
3	NEW CAP REL COSTS-BLDG & FIXT					3
3.01	NEW CAP RHC REL COSTS-BLDG & FI					3.01
4	NEW CAP REL COSTS-MVBLE EQUIP					4
5	EMPLOYEE BENEFITS					5
6	ADMINISTRATIVE & GENERAL					6
7	MAINTENANCE & REPAIRS					7
8	OPERATION OF PLANT					8
8.01	RHC UTILITY EXPENSE					8.01
9	LAUNDRY & LINEN SERVICE					9
10	HOUSEKEEPING					10
11	DIETARY					11
12	CAFETERIA					12
13	MAINTENANCE OF PERSONNEL					13
14	NURSING ADMINISTRATION					14
15	CENTRAL SERVICES & SUPPLY					15
16	PHARMACY					16
17	MEDICAL RECORDS & LIBRARY	587876				17
18	SOCIAL SERVICE					18
20	NONPHYSICIAN ANESTHETISTS					20
21	NURSING SCHOOL					21
22	I&R SERVICES-SALARY & FRINGES A					22
23	I&R SERVICES-OTHER PRGM COSTS A					23
24	PARAMED ED PRGM-(SPECIFY)					24
	INPATIENT ROUTINE SERV COST CENTERS					
25	ADULTS & PEDIATRICS	120288	2470549	2470549		25
	ANCILLARY SERVICE COST CENTERS					
37	OPERATING ROOM	32247	1178048	1178048		37
40	ANESTHESIOLOGY					40
41	RADIOLOGY-DIAGNOSTIC	295346	1943253	1943253		41
44	LABORATORY		1587341	1587341		44
46.30	BLOOD CLOTTING FACTORS ADMIN CO					46.30
49	RESPIRATORY THERAPY		379039	379039		49
50	PHYSICAL THERAPY		756994	756994		50
53	ELECTROCARDIOLOGY		80966	80966		53
54	ELECTROENCEPHALOGRAPHY		33270	33270		54
55	MEDICAL SUPPLIES CHARGED TO PAT		449211	449211		55
56	DRUGS CHARGED TO PATIENTS		757385	757385		56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI		619039	619039		59
59.97	CARDIAC REHABILITATION					59.97
59.98	HYPERBARIC OXYGEN THERAPY					59.98
59.99	LITHOTRIPSY					59.99
	OUTPATIENT SERVICE COST CENTERS					
61	EMERGENCY	139995	1770429	1770429		61
62	OBSERVATION BEDS (NON-DISTINCT					62
63.50	RHC		3073160	3073160		63.50
63.60	FQHC					63.60
	OTHER REIMBURSABLE COST CENTERS					
65	AMBULANCE SERVICES		816654	816654		65
69.10	CMHC					69.10
69.20	OUTPATIENT PHYSICAL THERAPY					69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY					69.30
69.40	OUTPATIENT SPEECH PATHOLOGY					69.40
71	HOME HEALTH AGENCY					71
	SPECIAL PURPOSE COST CENTERS					
85.01	PANCREAS ACQUISITION					85.01
85.02	INTESTINAL ACQUISITION					85.02
85.03	ISLET CELL ACQUISITION					85.03
95	SUBTOTALS	587876	15915338	15915338		95
	NONREIMBURSABLE COST CENTERS					
96	GIFT, FLOWER, COFFEE SHOP & CAN		11995	11995		96
98	PHYSICIANS' PRIVATE OFFICES		133114	133114		98
101	CROSS FOOT ADJUSTMENTS					101
102	NEGATIVE COST CENTER					102
103	TOTAL	587876	16060447	16060447		103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW RHC BUILDING FIXTURES 3.01	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	EMPLOYEE BENEFITS 5	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
3.01	NEW CAP RHC REL COSTS-BLDG & FI									3.01
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS				526	526	526			5
6	ADMINISTRATIVE & GENERAL		294653		51676	346329	49	346378		6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT		5074		12801	17875	11	13998	31884	8
8.01	RHC UTILITY EXPENSE							757		8.01
9	LAUNDRY & LINEN SERVICE				222	222		1923		9
10	HOUSEKEEPING		2784		1164	3948	14	7213	239	10
11	DIETARY		11830		11678	23508	14	8135	1014	11
12	CAFETERIA		3796			3796		95	325	12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION		4087		929	5016	20	9621	350	14
15	CENTRAL SERVICES & SUPPLY		5517		2301	7818	2	928	473	15
16	PHARMACY		3075		2213	5288	13	6027	264	16
17	MEDICAL RECORDS & LIBRARY		41640		17690	59330	18	10588	3569	17
18	SOCIAL SERVICE									18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		81673		36394	118067	74	36731	7002	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		51458		62896	114354	28	19690	4411	37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC		38009		290372	328381	23	32150	3258	41
44	LABORATORY		12083		62113	74196	28	31166	1036	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY		4251		8789	13040	13	6769	364	49
50	PHYSICAL THERAPY			49688	18416	68104	30	15373		50
53	ELECTROCARDIOLOGY		4251		4144	8395	3	1515	364	53
54	ELECTROENCEPHALOGRAPHY		4239		2676	6915	1	554	363	54
55	MEDICAL SUPPLIES CHARGED TO PAT							9530		55
56	DRUGS CHARGED TO PATIENTS							9745		56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI		32669			32669		12040	2800	59
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		34428		18746	53174	33	31095	2951	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC			140809	50756	191565	123	63694		63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES		16069		40796	56865	27	15086	1377	65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS		651586	190497	697298	1539381	524	344423	30160	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN		3404			3404		85	292	96
98	PHYSICIANS' PRIVATE OFFICES		16701	11522	421	28644	2	1870	1432	98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL		671691	202019	697719	1571429	526	346378	31884	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	RHC UTILITY EXPENSE 8.01	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINIS-TRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
3.01	NEW CAP RHC REL COSTS-BLDG & FI									3.01
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
8.01	RHC UTILITY EXPENSE	757								8.01
9	LAUNDRY & LINEN SERVICE		2145							9
10	HOUSEKEEPING			11414						10
11	DIETARY		32	467	33170					11
12	CAFETERIA			516	23406	28138				12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION			22		930	15959			14
15	CENTRAL SERVICES & SUPPLY		33	80		233	203	9770		15
16	PHARMACY			97		465	431	4	12589	16
17	MEDICAL RECORDS & LIBRARY			110		1860				17
18	SOCIAL SERVICE									18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		1014	3629	9764	6279	5527	181		25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		256	1592		1628	1495	3488		37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC		215	693		1628	1383	408		41
44	LABORATORY			398		2325	1968	3885		44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY			414		1163	1089	99		49
50	PHYSICAL THERAPY	186	120	381		1628		128		50
53	ELECTROCARDIOLOGY		31	67				2		53
54	ELECTROENCEPHALOGRAPHY			6						54
55	MEDICAL SUPPLIES CHARGED TO PAT							1100		55
56	DRUGS CHARGED TO PATIENTS								12589	56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI			126						59
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		333	1314		1860	1826	230		61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	528	45	985		5581		210		63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES		66	20		2325	2037	35		65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	714	2145	10917	33170	27905	15959	9770	12589	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN			71						96
98	PHYSICIANS' PRIVATE OFFICES	43		426		233				98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	757	2145	11414	33170	28138	15959	9770	12589	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 17	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 27	
	GENERAL SERVICE COST CENTERS					
1	OLD CAP REL COSTS-BLDG & FIXT					1
2	OLD CAP REL COSTS-MVBLE EQUIP					2
3	NEW CAP REL COSTS-BLDG & FIXT					3
3.01	NEW CAP RHC REL COSTS-BLDG & FI					3.01
4	NEW CAP REL COSTS-MVBLE EQUIP					4
5	EMPLOYEE BENEFITS					5
6	ADMINISTRATIVE & GENERAL					6
7	MAINTENANCE & REPAIRS					7
8	OPERATION OF PLANT					8
8.01	RHC UTILITY EXPENSE					8.01
9	LAUNDRY & LINEN SERVICE					9
10	HOUSEKEEPING					10
11	DIETARY					11
12	CAFETERIA					12
13	MAINTENANCE OF PERSONNEL					13
14	NURSING ADMINISTRATION					14
15	CENTRAL SERVICES & SUPPLY					15
16	PHARMACY					16
17	MEDICAL RECORDS & LIBRARY	75475				17
18	SOCIAL SERVICE					18
20	NONPHYSICIAN ANESTHETISTS					20
21	NURSING SCHOOL					21
22	I&R SERVICES-SALARY & FRINGES A					22
23	I&R SERVICES-OTHER PRGM COSTS A					23
24	PARAMED ED PRGM-(SPECIFY)					24
	INPATIENT ROUTINE SERV COST CENTERS					
25	ADULTS & PEDIATRICS	15443	203711		203711	25
	ANCILLARY SERVICE COST CENTERS					
37	OPERATING ROOM	4140	151082		151082	37
40	ANESTHESIOLOGY					40
41	RADIOLOGY-DIAGNOSTIC	37919	406058		406058	41
44	LABORATORY		115002		115002	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO					46.30
49	RESPIRATORY THERAPY		22951		22951	49
50	PHYSICAL THERAPY		85950		85950	50
53	ELECTROCARDIOLOGY		10377		10377	53
54	ELECTROENCEPHALOGRAPHY		7839		7839	54
55	MEDICAL SUPPLIES CHARGED TO PAT		10630		10630	55
56	DRUGS CHARGED TO PATIENTS		22334		22334	56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI		47635		47635	59
59.97	CARDIAC REHABILITATION					59.97
59.98	HYPERBARIC OXYGEN THERAPY					59.98
59.99	LITHOTRIPSY					59.99
	OUTPATIENT SERVICE COST CENTERS					
61	EMERGENCY	17973	110789		110789	61
62	OBSERVATION BEDS (NON-DISTINCT					62
63.50	RHC		262731		262731	63.50
63.60	FQHC					63.60
	OTHER REIMBURSABLE COST CENTERS					
65	AMBULANCE SERVICES		77838		77838	65
69.10	CMHC					69.10
69.20	OUTPATIENT PHYSICAL THERAPY					69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY					69.30
69.40	OUTPATIENT SPEECH PATHOLOGY					69.40
71	HOME HEALTH AGENCY					71
	SPECIAL PURPOSE COST CENTERS					
85.01	PANCREAS ACQUISITION					85.01
85.02	INTESTINAL ACQUISITION					85.02
85.03	ISLET CELL ACQUISITION					85.03
95	SUBTOTALS	75475	1534927		1534927	95
	NONREIMBURSABLE COST CENTERS					
96	GIFT, FLOWER, COFFEE SHOP & CAN		3852		3852	96
98	PHYSICIANS' PRIVATE OFFICES		32650		32650	98
101	CROSS FOOT ADJUSTMENTS					101
102	NEGATIVE COST CENTER					102
103	TOTAL	75475	1571429		1571429	103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW RHC BUILDING FIXTURES SQUARE FEET 3.01	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON-CILIATION 6A	ADMINIS-TRATIVE & GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8	
	GENERAL SERVICE COST CENTERS								
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	53087							3
3.01	NEW CAP RHC REL COSTS-BLDG &		15885						3.01
4	NEW CAP REL COSTS-MVBLE EQUIP			680713					4
5	EMPLOYEE BENEFITS			513	6999467				5
6	ADMINISTRATIVE & GENERAL	23288		50416	650002	-2238196	13822251		6
7	MAINTENANCE & REPAIRS								7
8	OPERATION OF PLANT	401		12489	140757		558587	29398	8
8.01	RHC UTILITY EXPENSE						30226		8.01
9	LAUNDRY & LINEN SERVICE			217			76720		9
10	HOUSEKEEPING	220		1136	183568		287829	220	10
11	DIETARY	935		11393	189217		324633	935	11
12	CAFETERIA	300					3796	300	12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION	323		906	269455		383936	323	14
15	CENTRAL SERVICES & SUPPLY	436		2245	22771		37013	436	15
16	PHARMACY	243		2159	169302		240523	243	16
17	MEDICAL RECORDS & LIBRARY	3291		17259	244212		422520	3291	17
18	SOCIAL SERVICE								18
20	NONPHYSICIAN ANESTHETISTS								20
21	NURSING SCHOOL								21
22	I&R SERVICES-SALARY & FRINGES								22
23	I&R SERVICES-OTHER PRGM COSTS								23
24	PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	6455		35507	984306		1465794	6455	25
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	4067		61363	373411		785740	4067	37
40	ANESTHESIOLOGY								40
41	RADIOLOGY-DIAGNOSTIC	3004		283294	305497		1282974	3004	41
44	LABORATORY	955		60599	378228		1243693	955	44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY	336		8575	178550		270103	336	49
50	PHYSICAL THERAPY		3907	17967	400497		613474		50
53	ELECTROCARDIOLOGY	336		4043	34183		60451	336	53
54	ELECTROENCEPHALOGRAPHY	335		2611	11394		22111	335	54
55	MEDICAL SUPPLIES CHARGED TO P						380317		55
56	DRUGS CHARGED TO PATIENTS						388882		56
59	PSYCHIATRIC/PSYCHOLOGICAL SER	2582					480486	2582	59
59.97	CARDIAC REHABILITATION								59.97
59.98	HYPERBARIC OXYGEN THERAPY								59.98
59.99	LITHOTRIPSY								59.99
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	2721		18289	445372		1240862	2721	61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RHC		11072	49519	1623522		2541559		63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES	1270		39802	366507		602008	1270	65
69.10	CMHC								69.10
69.20	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	OUTPATIENT OCCUPATIONAL THERA								69.30
69.40	OUTPATIENT SPEECH PATHOLOGY								69.40
71	HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
85.01	PANCREAS ACQUISITION								85.01
85.02	INTESTINAL ACQUISITION								85.02
85.03	ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	51498	14979	680302	6970751	-2238196	13744237	27809	95
	NONREIMBURSABLE COST CENTERS								
96	GIFT, FLOWER, COFFEE SHOP & C	269					3404	269	96
98	PHYSICIANS' PRIVATE OFFICES	1320	906	411	28716		74610	1320	98

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW RHC BUILDING FIXTURES SQUARE FEET 3.01	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON-CILIATION 6A	ADMINIS-TRATIVE & GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8	
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I	671691	202019	697719	2234513		2238196	649037	103
104	UNIT COST MULT-WS B PT I		12.717595		.319240		.161927		104
104	UNIT COST MULT-WS B PT I	12.652646		1.024983				22.077590	104
105	COST TO BE ALLOC PER B PT II								105
106	UNIT COST MULT-WS B PT II								106
106	UNIT COST MULT-WS B PT II								106
107	COST TO BE ALLOC PER B PT III				526		346378	31884	107
108	UNIT COST MULT-WS B PT III				.000075		.025059		108
108	UNIT COST MULT-WS B PT III							1.084564	108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	RHC UTILITY EXPENSE SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA FTE	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	
		8.01	9	10	11	12	14	15	16	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
3.01	NEW CAP RHC REL COSTS-BLDG &									3.01
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
8.01	RHC UTILITY EXPENSE	15885								8.01
9	LAUNDRY & LINEN SERVICE		22028							9
10	HOUSEKEEPING			14858						10
11	DIETARY		333	608	56327					11
12	CAFETERIA			672	39747	121				12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION			28		4	146887			14
15	CENTRAL SERVICES & SUPPLY		338	104		1	1864	808569		15
16	PHARMACY			126		2	3966	345	339292	16
17	MEDICAL RECORDS & LIBRARY			143		8				17
18	SOCIAL SERVICE									18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES									22
23	I&R SERVICES-OTHER PRGM COSTS									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		10418	4726	16580	27	50864	14953		25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		2626	2073		7	13764	288673		37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC		2204	902		7	12731	33755		41
44	LABORATORY			518		10	18118	321446		44
46.30	BLOOD CLOTTING FACTORS ADMIN									46.30
49	RESPIRATORY THERAPY			539		5	10020	8222		49
50	PHYSICAL THERAPY	3907	1230	496		7		10595		50
53	ELECTROCARDIOLOGY		323	87				172		53
54	ELECTROENCEPHALOGRAPHY			8						54
55	MEDICAL SUPPLIES CHARGED TO P							91076		55
56	DRUGS CHARGED TO PATIENTS								339292	56
59	PSYCHIATRIC/PSYCHOLOGICAL SER			164						59
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		3418	1710		8	16811	18999		61
62	OBSERVATION BEDS (NON-DISTINC									62
63.50	RHC	11072	458	1282		24		17411		63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES		680	26		10	18749	2922		65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERA									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	14979	22028	14212	56327	120	146887	808569	339292	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & C			92						96
98	PHYSICIANS' PRIVATE OFFICES	906		554		1				98

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	RHC UTILITY EXPENSE SQUARE FEET 8.01	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	HOUSE-KEEPING HOURS OF SERVICE 10	DIETARY MEALS SERVED 11	CAFETERIA FTE 12	NURSING ADMINIS-TRATION DIRECT NRSING HRS 14	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 15	PHARMACY COSTED REQUIS. 16	
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	COST TO BE ALLOC PER B PT I	35120	89143	339293	413075	317865	464384	64895	305533	103
104	UNIT COST MULT-WS B PT I	2.210891		22.835711		2626.983471		.080259		104
104	UNIT COST MULT-WS B PT I		4.046804		7.333517		3.161505		.900502	104
105	COST TO BE ALLOC PER B PT II									105
106	UNIT COST MULT-WS B PT II									106
106	UNIT COST MULT-WS B PT II									106
107	COST TO BE ALLOC PER B PT III	757	2145	11414	33170	28138	15959	9770	12589	107
108	UNIT COST MULT-WS B PT III	.047655		.768206		232.545455		.012083		108
108	UNIT COST MULT-WS B PT III		.097376		.588883		.108648		.037104	108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY TIME SPENT 17	
	GENERAL SERVICE COST CENTERS		
1	OLD CAP REL COSTS-BLDG & FIXT		1
2	OLD CAP REL COSTS-MVBLE EQUIP		2
3	NEW CAP REL COSTS-BLDG & FIXT		3
3.01	NEW CAP RHC REL COSTS-BLDG &		3.01
4	NEW CAP REL COSTS-MVBLE EQUIP		4
5	EMPLOYEE BENEFITS		5
6	ADMINISTRATIVE & GENERAL		6
7	MAINTENANCE & REPAIRS		7
8	OPERATION OF PLANT		8
8.01	RHC UTILITY EXPENSE		8.01
9	LAUNDRY & LINEN SERVICE		9
10	HOUSEKEEPING		10
11	DIETARY		11
12	CAFETERIA		12
13	MAINTENANCE OF PERSONNEL		13
14	NURSING ADMINISTRATION		14
15	CENTRAL SERVICES & SUPPLY		15
16	PHARMACY		16
17	MEDICAL RECORDS & LIBRARY	6891	17
18	SOCIAL SERVICE		18
20	NONPHYSICIAN ANESTHETISTS		20
21	NURSING SCHOOL		21
22	I&R SERVICES-SALARY & FRINGES		22
23	I&R SERVICES-OTHER PRGM COSTS		23
24	PARAMED ED PRGM-(SPECIFY)		24
	INPATIENT ROUTINE SERV COST CENTERS		
25	ADULTS & PEDIATRICS	1410	25
	ANCILLARY SERVICE COST CENTERS		
37	OPERATING ROOM	378	37
40	ANESTHESIOLOGY		40
41	RADIOLOGY-DIAGNOSTIC	3462	41
44	LABORATORY		44
46.30	BLOOD CLOTTING FACTORS ADMIN		46.30
49	RESPIRATORY THERAPY		49
50	PHYSICAL THERAPY		50
53	ELECTROCARDIOLOGY		53
54	ELECTROENCEPHALOGRAPHY		54
55	MEDICAL SUPPLIES CHARGED TO P		55
56	DRUGS CHARGED TO PATIENTS		56
59	PSYCHIATRIC/PSYCHOLOGICAL SER		59
59.97	CARDIAC REHABILITATION		59.97
59.98	HYPERBARIC OXYGEN THERAPY		59.98
59.99	LITHOTRIPSY		59.99
	OUTPATIENT SERVICE COST CENTERS		
61	EMERGENCY	1641	61
62	OBSERVATION BEDS (NON-DISTINC		62
63.50	RHC		63.50
63.60	FQHC		63.60
	OTHER REIMBURSABLE COST CENTERS		
65	AMBULANCE SERVICES		65
69.10	CMHC		69.10
69.20	OUTPATIENT PHYSICAL THERAPY		69.20
69.30	OUTPATIENT OCCUPATIONAL THERA		69.30
69.40	OUTPATIENT SPEECH PATHOLOGY		69.40
71	HOME HEALTH AGENCY		71
	SPECIAL PURPOSE COST CENTERS		
85.01	PANCREAS ACQUISITION		85.01
85.02	INTESTINAL ACQUISITION		85.02
85.03	ISLET CELL ACQUISITION		85.03
95	SUBTOTALS	6891	95
	NONREIMBURSABLE COST CENTERS		
96	GIFT, FLOWER, COFFEE SHOP & C		96
98	PHYSICIANS' PRIVATE OFFICES		98

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY TIME SPENT 17	
101	CROSS FOOT ADJUSTMENTS		101
102	NEGATIVE COST CENTER		102
103	COST TO BE ALLOC PER B PT I	587876	103
104	UNIT COST MULT-WS B PT I	85.310695	104
104	UNIT COST MULT-WS B PT I		104
105	COST TO BE ALLOC PER B PT II		105
106	UNIT COST MULT-WS B PT II		106
106	UNIT COST MULT-WS B PT II		106
107	COST TO BE ALLOC PER B PT III	75475	107
108	UNIT COST MULT-WS B PT III	10.952692	108
108	UNIT COST MULT-WS B PT III		108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS	2470549					25
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	1178048					37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC	1943253					41
44	LABORATORY	1587341					44
46.30	BLOOD CLOTTING FACTORS ADMI						46.30
49	RESPIRATORY THERAPY	379039					49
50	PHYSICAL THERAPY	756994					50
53	ELECTROCARDIOLOGY	80966					53
54	ELECTROENCEPHALOGRAPHY	33270					54
55	MEDICAL SUPPLIES CHARGED TO	449211					55
56	DRUGS CHARGED TO PATIENTS	757385					56
59	PSYCHIATRIC/PSYCHOLOGICAL S	619039					59
59.97	CARDIAC REHABILITATION						59.97
59.98	HYPERBARIC OXYGEN THERAPY						59.98
59.99	LITHOTRIPSY						59.99
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY	1770429					61
62	OBSERVATION BEDS (NON-DISTI	122842		122842		122842	62
63.50	RHC	3073160					63.50
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
65	AMBULANCE SERVICES	816654					65
101	SUBTOTAL	16038180		122842		122842	101
102	LESS OBSERVATION BEDS	122842		122842		122842	102
103	TOTAL	15915338					103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT 6	OUTPATIENT 7	TOTAL 8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	2158551		2158551				25
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	470853	1938459	2409312	.488956			37
40	ANESTHESIOLOGY							40
41	RADIOLOGY-DIAGNOSTIC	775786	6039422	6815208	.285135			41
44	LABORATORY	1147967	5393584	6541551	.242655			44
46.30	BLOOD CLOTTING FACTORS ADMI							46.30
49	RESPIRATORY THERAPY	322595	177213	499808	.758369			49
50	PHYSICAL THERAPY	180439	1905433	2085872	.362915			50
53	ELECTROCARDIOLOGY	48384	426257	474641	.170584			53
54	ELECTROENCEPHALOGRAPHY	2292	353275	355567	.093569			54
55	MEDICAL SUPPLIES CHARGED TO	1337559	1383979	2721538	.165058			55
56	DRUGS CHARGED TO PATIENTS	2509389	1398890	3908279	.193790			56
59	PSYCHIATRIC/PSYCHOLOGICAL S		950468	950468	.651299			59
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	90056	2315157	2405213	.736080			61
62	OBSERVATION BEDS (NON-DISTI	4399	139631	144030	.852892	.852892	.852892	62
63.50	RHC		1882149	1882149	1.632793			63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES		736934	736934	1.108178			65
101	SUBTOTAL	9048270	25040851	34089121				101
102	LESS OBSERVATION BEDS							102
103	TOTAL			34089121				103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES	[ ] TITLE V - O/P	[XX] HOSPITAL (14-1351)	[ ] SNF		
	[XX] TITLE XVIII-PT B	[ ] SUB I	[ ] NF		
	[ ] TITLE XIX - O/P	[ ] SUB II	[ ] S/B-SNF		
		[ ] SUB III	[ ] S/B-NF		
		[ ] SUB IV	[ ] ICF/MR		

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C, PART II COL. 8	PART I COL. 9	PART II COL. 9	PROGRAM CHARGES - OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC	
		1	1.01	1.02	2	3	4	
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	.488956	.488956	.488956				37
40	ANESTHESIOLOGY							40
41	RADIOLOGY-DIAGNOSTIC	.285135	.285135	.285135				41
44	LABORATORY	.242655	.242655	.242655				44
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	RESPIRATORY THERAPY	.758369	.758369	.758369				49
50	PHYSICAL THERAPY	.362915	.362915	.362915				50
53	ELECTROCARDIOLOGY	.170584	.170584	.170584				53
54	ELECTROENCEPHALOGRAPHY	.093569	.093569	.093569				54
55	MEDICAL SUPPLIES CHARGED TO PAT	.165058	.165058	.165058				55
56	DRUGS CHARGED TO PATIENTS	.193790	.193790	.193790				56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	.651299	.651299	.651299				59
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	.736080	.736080	.736080				61
62	OBSERVATION BEDS (NON-DISTINCT	.852892	.852892	.852892				62
63.50	RHC	1.632793	1.632793	1.632793				63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES	1.108178	1.108178	1.108178				65
65.01	AMBULANCE CHARGES (S-2 LINE 56.	1.108178	1.108178					65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56.	1.108178	1.108178					65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.	1.108178	1.108178					65.03
101	SUBTOTAL							101
102	CRNA CHARGES							102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104	NET CHARGES							104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.193790	1
2	VACCINE CHARGES (OTHER THAN HEPATITIS B)		2
2.01	VACCINE CHARGES - HEPATITIS B		2.01
3	VACCINE COSTS (OTHER THAN HEPATITIS B)		3
3.01	VACCINE COSTS - HEPATITIS B		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES	[ ] TITLE V - O/P	[XX] HOSPITAL (14-1351)	[ ] SNF		
	[XX] TITLE XVIII-PT B	[ ] SUB I	[ ] NF		
	[ ] TITLE XIX - O/P	[ ] SUB II	[ ] S/B-SNF		
		[ ] SUB III	[ ] S/B-NF		
		[ ] SUB IV	[ ] ICF/MR		

	COST CENTER DESCRIPTION	PROGRAM CHARGES ALL OTHER (1) (SEE INSTRU.) 5	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.01	PROGRAM CHARGES ALL OTHER (SEE INSTRU.) 5.02	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.03	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.04	PROGRAM COST OUTPATIENT AMBULATORY SURGICAL CENTER 6	PROGRAM COST OUTPATIENT RADIOLOGY 7	PROGRAM COST OTHER OUTPATIENT DIAGNOSTIC 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	995776								37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC	2550856								41
44	LABORATORY	2481808								44
46.30	BLOOD CLOTTING FACTORS ADMIN C									46.30
49	RESPIRATORY THERAPY	176988								49
50	PHYSICAL THERAPY	646681								50
53	ELECTROCARDIOLOGY	169482								53
54	ELECTROENCEPHALOGRAPHY	135238								54
55	MEDICAL SUPPLIES CHARGED TO PA	577228								55
56	DRUGS CHARGED TO PATIENTS	670919								56
59	PSYCHIATRIC/PSYCHOLOGICAL SERV	926511								59
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	957852								61
62	OBSERVATION BEDS (NON-DISTINCT	62894								62
63.50	RHC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES									65
65.01	AMBULANCE CHARGES (S-2 LINE 56									65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56									65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56									65.03
101	SUBTOTAL	10352233								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	10352233								104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK	[ ]	TITLE V - O/P	(XX)	HOSPITAL (14-1351)	[ ] SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ] NF
BOXES	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ] S/B-SNF
			[ ]	SUB III	[ ] S/B-NF
			[ ]	SUB IV	[ ] ICF/MR

	COST CENTER DESCRIPTION	PROGRAM COST ALL OTHER (COLS 1x5) 9	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.01) 9.01	PROGRAM COST ALL OTHER (COLUMNS 1.01x5.02) 9.02	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.03 9.03	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.04 9.04	HOSPITAL I/P PART B CHARGES (SEE INSTRU.) 10	HOSPITAL I/P PART B COST (COLUMNS 1.02x10) 11	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	486891							37
40	ANESTHESIOLOGY								40
41	RADIOLOGY-DIAGNOSTIC	727338							41
44	LABORATORY	602223							44
46.30	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	RESPIRATORY THERAPY	134222							49
50	PHYSICAL THERAPY	234690							50
53	ELECTROCARDIOLOGY	28911							53
54	ELECTROENCEPHALOGRAPHY	12654							54
55	MEDICAL SUPPLIES CHARGED TO PAT	95276							55
56	DRUGS CHARGED TO PATIENTS	130017							56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	603436							59
59.97	CARDIAC REHABILITATION								59.97
59.98	HYPERBARIC OXYGEN THERAPY								59.98
59.99	LITHOTRIPSY								59.99
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	705056							61
62	OBSERVATION BEDS (NON-DISTINCT	53642							62
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES								65
65.01	AMBULANCE CHARGES (S-2 LINE 56.								65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56.								65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.								65.03
101	SUBTOTAL	3814356							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	3814356							104

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS	HOSPITAL (OTHER) (14-1351) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	SNF 1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	4324						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3923						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3923						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	334						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	67						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2808						9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	334						10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	67						11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15	TOTAL NURSERY DAYS							15
16	TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

		HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	SNF	
	SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	100.00						19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	100.00						20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2470549						21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26	TOTAL SWING-BED COST	229115						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2241434						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2158551						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2158551						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.038398						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	550.23						33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2241434						37

COMPUTATION OF INPATIENT OPERATING COST — WORKSHEET D-1 PART II

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	571.36					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1604379					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1604379					41

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

		HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	1234504					48
49	TOTAL PROGRAM INPATIENT COSTS	2838883					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52	TOTAL PROGRAM EXCLUDABLE COST						52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
	TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
	PROGRAM INPATIENT ROUTINE SWING BED COST						
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	190834					60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	38281					61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	229115					62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

		SNF	
		1	
66	SNF/NF/ICF/MR ROUTINE SERVICE COST		66
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		67
68	PROGRAM ROUTINE SERVICE COST		68
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		70
71	CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS		71
72	PER DIEM CAPITAL RELATED COSTS		72
73	PROGRAM CAPITAL RELATED COSTS		73
74	INPATIENT ROUTINE SERVICE COST		74
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76	TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT		76
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78	INPATIENT ROUTINE SERVICE COST LIMITATION		78
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS		79
80	PROGRAM INPATIENT ANCILLARY SERVICES		80
81	UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82	TOTAL PROGRAM INPATIENT OPERATING COSTS		82

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

	HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	215					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	571.36					84
85 OBSERVATION BED COST	122842					85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V
[XX] TITLE XVIII-PT A
[ ] TITLE XIX

[XX] HOSPITAL (14-1351)
[ ] SUB I
[ ] SUB II
[ ] SUB III
[ ] SUB IV

[ ] SNF
[ ] NF
[ ] S/B-SNF
[ ] S/B-NF
[ ] ICF/MR

[ ] PPS
[ ] TEFRA
[XX] OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS		1606633		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.488956	453724	221851	37
40	ANESTHESIOLOGY				40
41	RADIOLOGY-DIAGNOSTIC	.285135	492478	140423	41
44	LABORATORY	.242655	758751	184115	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.758369	220725	167391	49
50	PHYSICAL THERAPY	.362915	108053	39214	50
53	ELECTROCARDIOLOGY	.170584	44266	7551	53
54	ELECTROENCEPHALOGRAPHY	.093569	2292	214	54
55	MEDICAL SUPPLIES CHARGED TO PAT	.165058	908331	149927	55
56	DRUGS CHARGED TO PATIENTS	.193790	1666086	322871	56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	.651299			59
59.97	CARDIAC REHABILITATION				59.97
59.98	HYPERBARIC OXYGEN THERAPY				59.98
59.99	LITHOTRIPSY				59.99
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.736080			61
62	OBSERVATION BEDS (NON-DISTINCT	.852892	1110	947	62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC	1.632793			63.50
63.60	FQHC				63.60
65	AMBULANCE SERVICES				65
101	TOTAL		4655816	1234504	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		4655816		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V	[ ] HOSPITAL	[ ] SNF	[ ] PPS
[XX] TITLE XVIII-PT A	[ ] SUB I	[ ] NF	[ ] TEFRA
[ ] TITLE XIX	[ ] SUB II	[XX] S/B-SNF (14-Z351)	[XX] OTHER
	[ ] SUB III	[ ] S/B-NF	
	[ ] SUB IV	[ ] ICF/MR	

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.488956			37
40	ANESTHESIOLOGY				40
41	RADIOLOGY-DIAGNOSTIC	.285135	16551	4719	41
44	LABORATORY	.242655	62890	15261	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.758369	33079	25086	49
50	PHYSICAL THERAPY	.362915	59740	21681	50
53	ELECTROCARDIOLOGY	.170584	1358	232	53
54	ELECTROENCEPHALOGRAPHY	.093569			54
55	MEDICAL SUPPLIES CHARGED TO PAT	.165058	86825	14331	55
56	DRUGS CHARGED TO PATIENTS	.193790	196567	38093	56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI	.651299			59
59.97	CARDIAC REHABILITATION				59.97
59.98	HYPERBARIC OXYGEN THERAPY				59.98
59.99	LITHOTRIPSY				59.99
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.736080			61
62	OBSERVATION BEDS (NON-DISTINCT	.852892			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC	1.632793			63.50
63.60	FQHC				63.60
65	AMBULANCE SERVICES				65
101	TOTAL		457010	119403	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		457010		103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1351) 1	HOSPITAL (14-1351) 1.01	HOSPITAL (14-1351) 1.02	
1	MEDICAL AND OTHER SERVICES	3814356			1
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				1.02
1.03	1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04	LINE 1.01 TIMES LINE 1.03				1.04
1.05	LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06	TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07	AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2	INTERNS AND RESIDENTS				2
3	ORGAN ACQUISITIONS				3
4	COST OF TEACHING PHYSICIANS				4
5	TOTAL COST	3814356			5
	COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6	ANCILLARY SERVICE CHARGES				6
7	INTERNS AND RESIDENTS SERVICE CHARGES				7
8	ORGAN ACQUISITION CHARGES				8
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10	TOTAL REASONABLE CHARGES				10
	CUSTOMARY CHARGES				
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)				12
13	RATIO OF LINE 11 TO LINE 12				13
14	TOTAL CUSTOMARY CHARGES				14
15	EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17	LESSER OF COST OR CHARGES	3852500			17
17.01	TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1351) 1	HOSPITAL (14-1351) 1.01	HOSPITAL (14-1351) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES	60350			18
18.01	COINSURANCE	1570905			18.01
19	SUBTOTAL	2221245			19
20	SUM OF AMOUNTS FROM WKST E, PARTS C,D & E				20
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS				21
22	ESRD DIRECT MEDICAL EDUCATION COSTS				22
23	SUBTOTAL	2221245			23
24	PRIMARY PAYER PAYMENTS	1174			24
25	SUBTOTAL	2220071			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS	398840			27
27.01	REDUCED REIMBURSABLE BAD DEBTS	398840			27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	398840			27.02
28	SUBTOTAL	2618911			28
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION				29
30	OTHER ADJUSTMENTS				30
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)				30.99
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS				31
32	SUBTOTAL	2618911			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	2407560			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM	211351			35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				36
	TO BE COMPLETED BY CONTRACTOR				
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)				50
51	OUTLIER RECONILIATION AMOUNT (SEE INSTRUCT				51
52	THE RATE USED TO CALCULATE THE TIME VALUE				52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)				53
54	TOTAL (SUM OF LINES 51 AND 53)				54

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
HOSPITAL (14-1351)

WORKSHEET E-1

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1844682		2404988	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01			05/29/2009	2572	3.01
		.02					3.02
		.03		NONE			3.03
		.04					3.04
		.05					3.05
		.50	05/29/2009	38906			3.50
	PROVIDER TO PROGRAM	.51					3.51
		.52				NONE	3.52
		.53					3.53
		.54					3.54
SUBTOTAL		.99		-38906		2572	3.99
4 TOTAL INTERIM PAYMENTS				1805776		2407560	4
TO BE COMPLETED BY INTERMEDIARY							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01					5.01
		.02					5.02
		.03					5.03
	PROVIDER TO PROGRAM	.50					5.50
		.51					5.51
		.52					5.52
SUBTOTAL		.99					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY							7

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1

SWING BED SKILLED NURSING FACILITY (14-Z351)

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				293271			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01					3.01
	PROGRAM TO PROVIDER	.02					3.02
		.03		NONE		NONE	3.03
		.04					3.04
		.05					3.05
		.50					3.50
	PROVIDER TO PROGRAM	.51					3.51
		.52		NONE		NONE	3.52
		.53					3.53
		.54					3.54
SUBTOTAL		.99					3.99
4 TOTAL INTERIM PAYMENTS				293271			4
TO BE COMPLETED BY INTERMEDIARY							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01					5.01
		.02					5.02
		.03					5.03
	PROVIDER TO PROGRAM	.50					5.50
		.51					5.51
		.52					5.52
SUBTOTAL		.99					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY							7

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

SUPPLEMENTAL
WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

		TITLE V S/B NF	--- TITLE XVIII --- S/B SNF PART A (14-Z351)	S/B SNF PART B	--- TITLE XIX --- S/B SNF (14-Z351)	S/B NF	
		1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		231406				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF						2
3	ANCILLARY SERVICES		120597				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						4
5	PROGRAM DAYS		401				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY						7
8	SUBTOTAL		352003				8
9	PRIMARY PAYER PAYMENTS						9
10	SUBTOTAL		352003				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)						11
12	SUBTOTAL		352003				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		14232				13
14	80% OF PART B COSTS						14
15	SUBTOTAL		337771				15
16	OTHER ADJUSTMENTS						16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)						17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES						17.01
18	TOTAL		337771				18
19	SEQUESTRATION ADJUSTMENT						19
20	INTERIM PAYMENTS		293271				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						20.01
21	BALANCE DUE PROVIDER/PROGRAM		44500				21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2						22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

		HOSPITAL (14-1351)	SUB I	SUB II	SUB III	SUB IV	SNF I	
1	INPATIENT SERVICES	2838883						1
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)							1.01
2	ORGAN ACQUISITION							2
3	COST OF TEACHING PHYSICIANS							3
4	SUBTOTAL	2838883						4
5	PRIMARY PAYER PAYMENTS							5
6	TOTAL COST	2867272						6
	COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES							
7	ROUTINE SERVICE CHARGES							7
8	ANCILLARY SERVICE CHARGES							8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE							9
10	TEACHING PHYSICIANS							10
11	TOTAL REASONABLE CHARGES							11
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENT LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS							12
13	AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							13
14	RATIO OF LINE 12 TO LINE 13							14
15	TOTAL CUSTOMARY CHARGES							15
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							16
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

		HOSPITAL (14-1351)	SUB I	SUB II	SUB III	SUB IV	SNF I	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT							
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS							18
19	COST OF COVERED SERVICES	2867272						19
20	DEDUCTIBLES	411276						20
21	EXCESS REASONABLE COST							21
22	SUBTOTAL	2455996						22
23	COINSURANCE	21977						23
24	SUBTOTAL	2434019						24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	69085						25
25.01	REDUCED REIMBURSABLE BAD DEBTS	69085						25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)							25.02
26	SUBTOTAL	2503104						26
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION							27
28	OTHER ADJUSTMENTS							28
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS							29
30	SUBTOTAL	2503104						30
31	SEQUESTRATION ADJUSTMENT							31
32	INTERIM PAYMENTS	1805776						32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							32.01
33	BALANCE DUE PROVIDER/PROGRAM	697328						33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2							34

BALANCE SHEET

WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1320576				1
2	TEMPORARY INVESTMENTS	5234393				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	2313754				4
5	OTHER RECEIVABLES	933278				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE					6
7	INVENTORY	201897				7
8	PREPAID EXPENSES	149364				8
9	OTHER CURRENT ASSETS	98984				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS	10252246				11
	FIXED ASSETS					
12	LAND	132111				12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS	345852				13
13.01	ACCUMULATED DEPRECIATION	-227923				13.01
14	BUILDINGS	11938973				14
14.01	ACCUMULATED DEPRECIATION	-5743780				14.01
15	LEASEHOLD IMPROVEMENTS					15
15.01	ACCUMULATED AMORTIZATION					15.01
16	FIXED EQUIPMENT	5717764				16
16.01	ACCUMULATED DEPRECIATION	-4238128				16.01
17	AUTOMOBILES AND TRUCKS					17
17.01	ACCUMULATED DEPRECIATION					17.01
18	MAJOR MOVABLE EQUIPMENT					18
18.01	ACCUMULATED DEPRECIATION					18.01
19	MINOR EQUIPMENT DEPRECIABLE					19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	7924869				21
	OTHER ASSETS					
22	INVESTMENTS					22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS	4292520				25
26	TOTAL OTHER ASSETS	4292520				26
27	TOTAL ASSETS	22469635				27

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	671771				28
29	SALARIES, WAGES & FEES PAYABLE	633848				29
30	PAYROLL TAXES PAYABLE					30
31	NOTES & LOANS PAYABLE (SHORT TERM)					31
32	DEFERRED INCOME					32
33	ACCELERATED PAYMENTS					33
34	DUE TO OTHER FUNDS					34
35	OTHER CURRENT LIABILITIES	300792				35
36	TOTAL CURRENT LIABILITIES	1606411				36
	LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE					37
38	NOTES PAYABLE	5655489				38
39	UNSECURED LOANS					39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66					40
41	OTHER LONG TERM LIABILITIES					41
42	TOTAL LONG TERM LIABILITIES	5655489				42
43	TOTAL LIABILITIES	7261900				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	15207735				44
45	SPECIFIC PURPOSE FUND BALANCE					45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED					46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED					47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL					48
49	PLANT FUND BALANCE - INVESTED IN PLANT					49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION					50
51	TOTAL FUND BALANCES	15207735				51
52	TOTAL LIABILITIES AND FUND BALANCES	22469635				52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
1	FUND BALANCES AT BEGINNING OF PERIOD	15376532				1
2	NET INCOME (LOSS)	-168797				2
3	TOTAL	15207735				3
4	ADDITIONS (CREDIT ADJUSTMENTS)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS					10
11	SUBTOTAL	15207735				11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	15207735				19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	2259764		2259764	1
2	SUBPROVIDER I				2
4	SWING BED - SNF				4
5	SWING BED - NF				5
6	SKILLED NURSING FACILITY				6
7	NURSING FACILITY				7
8	OTHER LONG TERM CARE				8
9	TOTAL GENERAL INPATIENT CARE SERVICES	2259764		2259764	9
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10	INTENSIVE CARE UNIT				10
11	CORONARY CARE UNIT				11
12	BURN INTENSIVE CARE UNIT				12
13	SURGICAL INTENSIVE CARE UNIT				13
14	OTHER SPECIAL CARE (SPECIFY)				14
15	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				15
16	TOTAL INPATIENT ROUTINE CARE SERVICES	2259764		2259764	16
17	ANCILLARY SERVICES	7138798		7138798	17
18	OUTPATIENT SERVICES		24595575	24595575	18
18.50	RHC		2213432	2213432	18.50
18.60	FQHC				18.60
19	HOME HEALTH AGENCY				19
20	AMBULANCE		736934	736934	20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24					24
25	TOTAL PATIENT REVENUES	9398562	27545941	36944503	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		17629864	26
27	PROVISION FOR UNCOLLECTIBLE ACCOUNT	1521997		27
28				28
29				29
30				30
31				31
32				32
33	TOTAL ADDITIONS		1521997	33
34	DEDUCT (SPECIFY)			34
35				35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS			39
40	TOTAL OPERATING EXPENSES		19151861	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	36944503	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	18870014	2
3	NET PATIENT REVENUES	18074489	3
4	LESS - TOTAL OPERATING EXPENSES	19151861	4
5	NET INCOME FROM SERVICE TO PATIENTS	-1077372	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	194762	6
7	INCOME FROM INVESTMENTS	225129	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	96556	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	5702	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	TAX REVENUE	240064	24
24.01	RENTAL INCOME	51929	24.01
24.02	MISCELLANEOUS INCOME	94433	24.02
25	TOTAL OTHER INCOME	908575	25
26	TOTAL	-168797	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	-168797	31

RHC I
COMPONENT NO: 14-3458

WORKSHEET M-1

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	880644		880644		880644	-119601	761043	1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER	246253		246253		246253		246253	3
4	VISITING NURSE								4
5	OTHER NURSE	268647		268647		268647		268647	5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	33233		33233		33233		33233	9
10	SUBTOTAL (SUM OF LINES 1-9)	1428777		1428777		1428777	-119601	1309176	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT		94436	94436		94436		94436	11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (SUM OF LINES 11-13)		94436	94436		94436		94436	14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		25807	25807		25807		25807	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE		31330	31330		31330		31330	18
19	OTHER HEALTH CARE COSTS		88557	88557		88557		88557	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		145694	145694		145694		145694	21
22	TOTAL COSTS OF HEALTH CARE SERVICES	1428777	240130	1668907		1668907	-119601	1549306	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS								28
	FACILITY OVERHEAD								
29	FACILITY COSTS	282393		282393		282393		282393	29
30	ADMINISTRATIVE COSTS								30
31	TOTAL FACILITY OVERHEAD	282393		282393		282393		282393	31
32	TOTAL FACILITY COSTS	1711170	240130	1951300		1951300	-119601	1831699	32

RHC I WORKSHEET M-2
COMPONENT NO: 14-3458

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	2.97	12158	4200	12474		1
2	PHYSICIAN ASSISTANTS			2100			2
3	NURSE PRACTITIONERS	2.52	9520	2100	5292		3
4	SUBTOTAL	5.49	21678		17766	21678	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS	5.49	21678			21678	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS		179			179	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES	1549306	10
11	TOTAL NONREIMBURSABLE COSTS		11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD)	1549306	12
13	RATIO OF RHC/FQHC SERVICES	1.000000	13
14	TOTAL FACILITY OVERHEAD	282393	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	1241461	15
16	TOTAL OVERHEAD	1523854	16
17	ALLOWABLE GME OVERHEAD		17
18	SUBTRACT LINE 17 FROM LINE 16	1523854	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	1523854	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	3073160	20

RHC I

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT NO: 14-3458

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES			3073160	1
2	COST OF VACCINES AND THEIR ADMINISTRATION			9024	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE			3064136	3
4	TOTAL VISITS			21678	4
5	PHYSICIANS VISITS UNDER AGREEMENT			179	5
6	TOTAL ADJUSTED VISITS			21857	6
7	ADJUSTED COST PER VISIT			140.19	7
		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 1	CALCULATION OF LIMIT(1) ON OR AFTER JANUARY 1 2	(SEE INSTR.) 3	
8	PER VISIT PAYMENT LIMIT				8
9	RATE FOR PROGRAM COVERED VISITS	140.19	140.19		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	6156			10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	863010			11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES				14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST				15
16	TOTAL PROGRAM COST			863010	16
16.01	PRIMARY PAYOR PAYMENTS			70	16.01
17	LESS: BENEFICIARY DEDUCTIBLE			67541	17
18	NET PROGRAM COST EXCLUDING VACCINES			795399	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			636319	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			9024	20
21	TOTAL REIMBURSABLE PROGRAM COST			645343	21
22	REIMBURSABLE BAD DEBTS			21068	22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES				22.01
23	OTHER ADJUSTMENTS				23
24	NET REIMBURSABLE AMOUNT			666411	24
25	INTERIM PAYMENTS			695547	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				25.01
26	BALANCE DUE COMPONENT/PROGRAM			-29136	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				27

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

RHC I WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT NO: 14-3458

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	H1N1 VACCINE (SERVICES ON/AFTER 10/1/2009) 2.01	COMBINATION INFLUENZA & H1N1 IN SAME VISIT 2.02	
1	HEALTH CARE STAFF COSTS	1309176	1309176	1309176	1309176	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000129	0.000734			2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	169	961			3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	972	2448			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	1141	3409			5
6	TOTAL DIRECT COST OF THE FACILITY	1549306	1549306	1549306	1549306	6
7	TOTAL OVERHEAD	1523854	1523854	1523854	1523854	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.000736	0.002200			8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	1122	3352			9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	2263	6761			10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	18	102			11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	125.72	66.28			12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	18	102			13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	2263	6761			14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		9024			15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		9024			16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER
FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

RHC I
COMPONENT NO: 14-3458

WORKSHEET M-5

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				632147	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01	09/04/2009	63400	3.01
		PROGRAM TO PROVIDER	.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
			.50			3.50
		PROVIDER TO PROGRAM	.51			3.51
			.52		NONE	3.52
			.53			3.53
			.54			3.54
	SUBTOTAL		.99		63400	3.99
4	TOTAL INTERIM PAYMENTS				695547	4
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01			5.01
			.02			5.02
			.03			5.03
		PROVIDER TO PROGRAM	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL		.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01			6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY					7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____ DATE (MO/DAY/YR): _____